



**Referral Form for Services at WestCoast Children's Clinic**

*Confidential*

Youth: \_\_\_\_\_

School: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parents: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Contact person: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to referred youth: \_\_\_\_\_

Best times to call: \_\_\_\_\_

Additional Contact (e.g. social worker) : \_\_\_\_\_

Phone: \_\_\_\_\_

*Please continue to page 2*

**Reason for Referring for Services and What Service is Requested (e.g. therapy, psychological testing, etc.)**

Please fax this confidential form to make a referral to WestCoast Children's Clinic.

An intake clinician or other agency representative will contact you if additional information is necessary or if the child is ineligible for services. If the information provided is sufficient to begin an intake, WCC will contact the family of the referred student.

FAX: 510-269-9031

**ATTN: INTAKE**